FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0012955

Facility Name: PROPHETS RIVERVIEW

Address: 310 MOSHER DRIVE (Number) PROPHETSTOWN (City) 61277 (Zip Code)

County: WHITESIDE

Telephone Number: (815)537-5175 **Fax #** (815)537-2628

IDPA ID Number: 45-0228055

Date of Initial License for Current Owners:

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ALETA CARLSON **Telephone Number:** (605)362-3843

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 3/25/02 (Date)
(Type or Print Name)
(Title) VICE PRESIDENT

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,548	13,136	1,541	24,225	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,548	13,136	1,541	24,225	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.81%

D. How many bed-hold days during this year were paid by Public Aid?
297 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy, Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 9/20/1967

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,541

Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	184,353	8,468	4,064	196,885		196,885		196,885			1
2	Food Purchase		129,009		129,009		129,009	(8,080)	120,929			2
3	Housekeeping	58,883	18,895		77,778		77,778		77,778			3
4	Laundry	53,849	16,231		70,080		70,080		70,080			4
5	Heat and Other Utilities			45,723	45,723		45,723	(4,585)	41,138			5
6	Maintenance	48,446	6,211	26,526	81,183		81,183	437	81,620			6
7	Other (specify):*			2,206	2,206		2,206	(311)	1,895			7
8	**TOTAL General Services**	345,531	178,814	78,519	602,864		602,864	(12,539)	590,325			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	965,238	87,050	13,983	1,066,271	(6,415)	1,059,856	(44,738)	1,015,116			10
10a	Therapy	7,319	133	36,733	44,185		44,185	(9,529)	34,656			10a
11	Activities	64,437	4,320	16,014	84,771		84,771	(954)	83,817			11
12	Social Services	28,183	12	1,820	30,015		30,015		30,015			12
13	Nurse Aide Training					6,415	6,415		6,415			13
14	Program Transportation			540	540	2,372	2,912		2,912			14
15	Other (specify):*	34,259			34,259		34,259		34,259			15
16	**TOTAL Health Care and Programs**	1,099,436	91,515	69,090	1,260,041	2,372	1,262,413	(55,221)	1,207,190			16
	C. General Administration											
17	Administrative	52,645		110,555	163,200		163,200	21,099	184,299			17
18	Directors Fees											18
19	Professional Services			19,218	19,218		19,218	(18,018)	1,200			19
20	Dues, Fees, Subscriptions & Promotions			10,108	10,108		10,108	(8,980)	1,128			20
21	Clerical & General Office Expenses	103,725	9,735	24,592	138,052		138,052	(7,079)	130,973			21
22	Employee Benefits & Payroll Taxes			321,588	321,588		321,588	27,321	348,909			22
23	Inservice Training & Education			7,936	7,936		7,936		7,936			23
24	Travel and Seminar			4,094	4,094	(2,372)	1,722		1,722			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			31,097	31,097		31,097	4,293	35,390			26
27	Other (specify):*											27
28	**TOTAL General Administration**	156,370	9,735	529,188	695,293	(2,372)	692,921	18,636	711,557			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,601,337	280,064	676,797	2,558,198		2,558,198	(49,124)	2,509,072			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PROPHETS RIVERVIEW #0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			150,551	150,551		150,551		150,551			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			480	480		480	(480)				34
35	Rent-Equipment & Vehicles			5,538	5,538		5,538		5,538			35
36	Other (specify):*											36
37	**TOTAL Ownership**			156,569	156,569		156,569	(480)	156,089			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			2,955	2,955		2,955	(2,955)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,325	38,325		38,325		38,325			42
43	Other (specify):*			3,435	3,435		3,435	(3,435)				43
44	**TOTAL Special Cost Centers**			44,715	44,715		44,715	(6,390)	38,325			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,601,337	280,064	878,081	2,759,482		2,759,482	(55,994)	2,703,486			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,079)	2		4
5	Telephone, TV & Radio in Resident Rooms	(480)	34		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,980)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(91,168)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (108,707)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 52,713		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (55,994)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PROPHETS RIVERVIEW

ID# 0012955

Report Period Beginning: 1/1/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Uniform Inc	$ (3,452)	21	1
2	Administration	(100)	21	2
3	Wanderguard	(3,525)	21	3
4	Postage	(4)	21	4
5	Resident Supplies	(311)	7	5
6	supplies - Med Par B	(2,660)	10	6
7	Cable TV	(4,585)	5	7
8	Prescr Drugs - Reimb	(33,536)	10	8
9	Barber/Beauty Expenses	(2,955)	40	9
10	Radio Service	(954)	11	10
11	Therapy Offset - PT, OT, ST	(9,529)	10A	11
12	Purch Svc - Laboratory	(1,567)	43	12
13	Purch Svc - Radiology	(1,454)	43	13
14	Contract Services - Lab	11	43	14
15	Contract Services - Radiology	(425)	43	15
16	Pro Services - Legal Fees	(18,018)	19	16
17	Pharmacy Risk Settle Up	(2,007)	10	17
18	Deferred Maint Exp - 2001	437	6	18
19	Proclaim Offset	(6,534)	10	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(91,168)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,079)	0	0	0	0	0	0	0	0	0	0	(8,079)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,585)	0	0	0	0	0	0	0	0	0	0	(4,585)	5
6	Maintenance	437	0	0	0	0	0	0	0	0	0	0	437	6
7	Other (specify):*	(311)	0	0	0	0	0	0	0	0	0	0	(311)	7
8	**TOTAL General Services**	(12,538)	0	0	0	0	0	0	0	0	0	0	(12,538)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(44,737)	0	0	0	0	0	0	0	0	0	0	(44,737)	10
10a	Therapy	(9,529)	0	0	0	0	0	0	0	0	0	0	(9,529)	10a
11	Activities	(954)	0	0	0	0	0	0	0	0	0	0	(954)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(55,220)	0	0	0	0	0	0	0	0	0	0	(55,220)	16
	C. General Administration													
17	Administrative	0	21,099	0	0	0	0	0	0	0	0	0	21,099	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,018)	0	0	0	0	0	0	0	0	0	0	(18,018)	19
20	Fees, Subscriptions & Promotions	(8,980)	0	0	0	0	0	0	0	0	0	0	(8,980)	20
21	Clerical & General Office Expenses	(7,081)	0	0	0	0	0	0	0	0	0	0	(7,081)	21
22	Employee Benefits & Payroll Taxes	0	27,321	0	0	0	0	0	0	0	0	0	27,321	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	4,293	0	0	0	0	0	0	0	0	0	4,293	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(34,079)	52,713	0	0	0	0	0	0	0	0	0	18,634	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(101,837)	52,713	0	0	0	0	0	0	0	0	0	(49,124)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(480)	0	0	0	0	0	0	0	0	0	0	(480)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(480)	0	0	0	0	0	0	0	0	0	0	(480)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(2,955)	0	0	0	0	0	0	0	0	0	0	(2,955)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(3,435)	0	0	0	0	0	0	0	0	0	0	(3,435)	43
44	**TOTAL Special Cost Centers**	(6,390)	0	0	0	0	0	0	0	0	0	0	(6,390)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(108,707)	52,713	0	0	0	0	0	0	0	0	0	(55,994)	45

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Ev Lutheran	100%					
Good Samaritan Society						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Admin/Acctg	$ 110,555	The Ev Lutheran Good Samaritan Society	100.00%	$ 131,654	$ 21,099	1
2	V									2
3	V		22	Unemployment	6,855			6,970	115	3
4	V									4
5	V		22	Workers Comp	40,630			43,708	3,078	5
6	V									6
7	V		26	Insuranse	31,097			35,390	4,293	7
8	V									8
9	V		22	Health Ins	128,022			152,150	24,128	9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 317,159			$ 369,872	$ * 52,713	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1			NOT APPLICABLE						$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: The EV Lutheran Good Samaritan Society
Street Address: 4800 W 57th St PO Box 5038
City / State / Zip Code: Sioux Falls, SD 57117-5038
Phone Number: (605) 362-3100
Fax Number: (605) 362-3265

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2			NO ALLOCATION NECESSARY							2
3										3
4			SEE REPORT ON ALLOWABLE CENTRAL OFFICE EXPENSES FOR THE YEAR ENDED DECEMBER 31, 2002							4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	NOT APPLICABLE						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PROPHETS RIVERVIEW COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0012955

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,259 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

APARTMENTS - 4

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1966	$ 15,000	1
2					2
3	TOTALS			$ 15,000	3

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1967	1967	$ 347,119	$ 8,678	40	$ 8,678	$	$ 305,897	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11	Building										11
12			1973	1973	669	17	40	17		488	12
13			1974	1974	483	12	40	12		344	13
14			1975	1975	31,653	791	varies	791		22,158	14
15			1977	1977	4,675	-	20	-		4,675	15
16			1979	1979	7,265	-	20	-		7,265	16
17			1980	1980	2,114	92	varies	92		1,964	17
18			1981	1981	58,599	1,404	varies	1,404		32,254	18
19			1982	1982	8,456	268	varies	268		8,456	19
20			1983	1983	14,821	741	varies	741		14,512	20
21			1984	1984	8,772	439	varies	439		8,023	21
22			1985	1985	25,345	699	varies	699		23,808	22
23			1986	1986	7,033	15	varies	15		6,978	23
24			1987	1987	78,081	3,616	varies	3,616		60,349	24
25			1988	1988	48,076	1,128	varies	1,128		33,610	25
26			1989	1989	102,492	448	varies	448		101,758	26
27			1990	1990	922,006	41,756	varies	41,756		640,799	27
28			1991	1991	5,729	167	varies	167		5,101	28
29			1992	1992	24,954	696	varies	696		21,560	29
30			1993	1993	11,808	381	varies	381		9,497	30
31			1994	1994	45,574	1,000	varies	1,000		37,361	31
32			1995	1995	31,371	1,133	varies	1,133		23,723	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PROPHETS RIVERVIEW **#** 0012955 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Floor Covering for Maint Room	1996	$ 605	$ 61	10	$ 61	$	$ 424	37
38	Bath Cabinets for Resident	1996	784	39	20	39		274	38
39	Ceiling Tile	1996	496	50	10	50		347	39
40	FRP Board and Supplies for 200	1996	205	14	15	14		95	40
41	Replace Water Lines from Boile	1996	6,000	240	25	240		1,620	41
42	Sanitizing Room/1/2 Down Payment	1996	5,497	550	10	550		3,802	42
43	Install Kemlite in 200 Wing	1996	453	23	20	23		155	43
44	Counter Top/Dining Room	1996	365	18	20	18		122	44
45	Lavatory Water Closet Tank	1996	445	22	20	22		148	45
46	York A/C Unit for 300 Wing	1996	7,100	473	15	473		3,077	46
47	Isolation Valves on Circulation	1996	1,300	130	10	130		834	47
48	Remove & Replace Counter	1996	600	40	15	40		257	48
49	AT & Partner Sys Configuration	1996	8,646	-	6	-		8,226	49
50	Steel Fire Doors	1996	2,857	143	20	143		917	50
51	Air Compressor for Air Handler	1996	511	-	5	-		488	51
52	Install Windows & Screens	1996	420	28	15	28		177	52
53	Water System	1996	4,500	225	20	225		1,406	53
54	Six Birch Doors	1997	590	39	15	39		229	54
55	Amplifier-Intercom	1997	618	62	10	62		355	55
56	12000 BTU's Goodman Air Conditioner	1997	378	25	5	25		378	56
57	Green Louvered Shutters	1997	475	47	10	47		269	57
58	Install New Booster Heater	1997	1,286	129	10	129		718	58
59	Replaced Motor Coupling	1997	1,559	156	10	156		871	59
60	Reconfigured Water Heat Loop	1997	1,800	180	10	180		1,005	60
61	18 Rooms/Closet Doors/Complet	1997	6,320	421	15	421		2,317	61
62	Outdoor Home Sign	1997	1,000	67	15	67		367	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	**TOTAL (lines 4 thru 69)**		**$ 1,841,905**	**$ 66,663**		**$ 66,663**	**$**	**$ 1,399,458**	70

****Improvement type must be detailed in order for the cost report to be considered complete.**

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2(Endi 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustme	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,841,905	$ 66,663		$ 66,663	$	$ 1,399,458	1
2	36" Door Frame Guards/Contact	1997	1127	75	15	75		419	2
3	Outdoor Nursing Home Sign	1997	2000	200	10	200		1083	3
4	Remodel Bath/Clean & Soiled	1997	33471	1339	25	1339		7810	4
5	Plumbing-Remodel 100 Wing	1997	504	25	20	25		147	5
6	Cabinets	1998	858	57	15	57		272	6
7	Counter Tops	1998	2326	155	15	155		736	7
8	Photo Electric Smoke Detector	1998	420	42	10	42		193	8
9	Lavatory Faucet With Pop Up	1998	362	18	20	18		84	9
10	Plastering Walls	1998	2500	500	5	500		2292	10
11	Labor Material for Wallpaper	1998	3966	397	10	397		1785	11
12	Wallpaper & Border-Dining Room	1998	1529	306	5	306		1376	12
13	Wallpaper & Border-Dining Room	1998	2925	585	5	585		2632	13
14	Material for Wall and Painting	1998	6125	1225	5	1225		5411	14
15	Toilet & Tank	1998	373	37	10	37		165	15
16	Dining Room and Doors Korogard	1998	5925	395	15	395		1744	16
17	Nurses Station	1998	6401	427	15	427		1814	17
18	Wallcovering	1998	5209	1042	5	1042		4427	18
19	Carpet 450 Sq. Yards	1998	10077	2015	5	2015		8734	19
20	Material and Labor to Cable	1998	6033	302	20	302		1307	20
21	Staff Entrance Hall Flooring	1998	1151	230	5	230		940	21
22	Plumbing Repair	1999	2644	264	10	264		1058	22
23	Carpet	1999	3750	776	5	776		3103	23
24	Door on 300 Wing	1999	600	40	15	40		160	24
25	Grease Trap	1999	626	62	10	62		250	25
26	Lavatory Faucets	1999	732	37	20	37		143	26
27	Entrance Door on 300 Wing	1999	600	40	15	40		150	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,944,139	$ 77,254		$ 77,254	$ #	$ 1,447,693	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 End 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,944,139	$ 77,254		$ 77,254	$	$ 1,447,693	1
2	Pulled Stool Flange	1999	443	44	10	44		166	2
3	Boiler	1999	693	69	10	69		256	3
4	Gutters Replacement	1999	8,260	826	10	826		2,960	4
5	Rebuilt Corner/Overh. Porch	1999	560	56	10	56		196	5
6	Faucets	1999	1,069	54	20	54		187	6
7	Toilet Tanks	1999	1,628	81	20	81		285	7
8	Water Heater	2000	4,981	498	10	498		1,453	8
9	Flooring	2000	1,338	268	5	268		647	9
10	AM Standard Faucets	2000	953	48	20	48		117	10
11	Generator Repair	2000	966	97	10	97		225	11
12	Vinyl Floor Finish-Resident Room	2000	7,427	743	10	743		1,544	12
13	Vinyl Flooring	2001	477	48	10	48		95	13
14	Lockset	2001	1,314	88	15	88		175	14
15	Door Locks	2001	1,825	122	15	122		243	15
16	Toilet	2001	353	18	20	18		32	16
17	Fire Alarm Panel	2001	395	25	15	25		66	17
18	Carpet for Wing Halls	2001	13,485	2,697	5	2,697		4,945	18
19	Carpet for Chapel & Hallway	2001	5,820	1,164	5	1,164		2,037	19
20	Toilets	2001	353	18	20	18		32	20
21	Air Conditioner	2001	708	142	5	142		236	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	**TOTAL (lines 1 thru 33)**		**$ 1,997,187**	**$ 84,360**		**$ 84,360**	**$ 0**	**$ 1,463,590**	34

****Improvement type must be detailed in order for the cost report to be considered complete.**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 E 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,997,187	$ 84,360		$ 84,360	$	$ 1,463,590	1
2	AC for Beauty Shop	2001	329	66	5	66		110	2
3	Ceiling for Dining Room		1,394	93	15	93		116	3
4	Wall Unit, Panels, Priv Screen		967	65	15	65		91	4
5	Corner Guards-Resident Room	2001	162	16	10	16		18	5
6	Doors-Resident Room	2001	1,770	118	15	118		128	6
7	Duct Work-Resident Room		2,139	107	20	107		116	7
8	Interior Partitions-Resid RM		844	56	15	56		61	8
9	Paint-Resident Room Remodel	2001	181	36	5	36		39	9
10	Corner Guards-Resident Room	2001	558	56	10	56		61	10
11	Wallpaper-Resident Room Remode	2001	6,694	1,339	5	1,339		1,450	11
12	CIP - Building - Nursing - Ventilation	2002	143,372	9,558	15	9,558		9,558	12
13	Carpet	2002	1,107	166	5	166		166	13
14	Cabinet, window-kitchen	2002	1,726	101	10	101		101	14
15	Blinds-Remodel 8 Rooms	2002	217	4	5	4		4	15
16	Building-Remodel 8 Rooms	2002	924	3	25	3		3	16
17	Corner Guards-Remodel 8 Rooms	2002	139	1	10	1		1	17
18	Drapes-Remodel 8 Rooms	2002	14	0	5	0		0	18
19	Duct Work - Remodel 8 Rooms	2002	1,115	5	20	5		5	19
20	Plumbing-Remodel 8 Rooms	2002	354	2	15	2		2	20
21	Shades	2002	364	6	5	6		6	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,161,557	$ 96,158		$ 96,158	$ 0	$ 1,475,626	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,161,557	$ 96,158		$ 96,158	$	$ 1,475,626	1
2	Land Improvements	1967	1,223	-	15	-		1,223	2
3		1975	3,363	-	15	-		3,363	3
4		1978	2,854	-	15	-		2,854	4
5		1979	2,940	-	15	-		2,940	5
6		1981	2,147	-	10	-		2,147	6
7		1982	2,492	-	10	-		2,492	7
8		1983	1,250	-	10	-		1,250	8
9		1990	1,418		10			1,418	9
10		1991	3,967	124	varies	124		3,501	10
11		1992	7,076	549	varies	549		6,295	11
12		1993	427	43	10	43		407	12
13		1994	1,049	70	15	70		606	13
14		1995	5,652	415	varies	415		4,614	14
15	Gazebo & Preparation	1996	3,234	162	20	162		1,078	15
16	Remove Existing Payment/Comple	1997	7,844	392	20	392		2,124	16
17	Seal Coat Front Parking Lot	1997	2,500	250	10	250		1,354	17
18	Mulch Edging Fabric Weed	1998	583	116	5	116		533	18
19	Edging Pipe Drain Elbow	1998	1,061	106	10	106		487	19
20	Gutter Screen Retaining Wall	1998	902	90	10	90		399	20
21	Perennial/Planting/Landscaping	1999	1,727	155	10	155		483	21
22	Landscaping	2000	1,094	109	10	109		264	22
23	Parking Lot Overlay/Seal	2001	22,000	1,100	20	1,100		1,467	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,238,360	$ 99,839		$ 99,839	$ 0	$ 1,516,925	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 455,820	$ 43,789	$ 43,789	$		$ 478,367	71
72	Current Year Purchases	54,377	2,723	2,723			2,715	72
73	Fully Depreciated Assets	239,294						73
74								74
75	TOTALS	$ 749,491	$ 46,512	$ 46,512	$		$ 481,082	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Van	1992	$ 35,985	$	$	$		$ 35,985	76
77	Resident Care	1988 Cadillac Brougham	2000	3,510	878	878			2,048	77
78										78
79										79
80	TOTALS			$ 39,495	$ 878	$ 878	$		$ 38,033	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,645,891	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 147,229	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 147,229	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,918,573	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartments Unit 40	$	$	$	86
87	Building	67,444	2,465	46,134	87
88	FFE	9,826	352	8,871	88
89					89
90					90
91	TOTALS	$ 77,270	$ 2,817	$ 55,005	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 5,538 Description: Computer equip lease, air fluid thpy bed, miscellaneous
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [X]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE 96

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [X]
   - HOURS PER AIDE 48

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$ 200	$ 1,755	$	$ 1,955
2	Books and Supplies		40	200		240
3	Classroom Wages	(a)	223	2,475		2,698
4	Clinical Wages	(b)		1,272		1,272
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			250		250
9	TOTALS		$ 463	$ 5,952	$	$ 6,415
10	SUM OF line 9, col. 1 and 2	(e)	$ 6,415			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	7

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$	303	$ 13,988	$	303	$ 13,988	1
2	Licensed Speech and Language Development Therapist		hrs		25	1,916		25	1,916	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		444	20,829		444	20,829	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	772	$ 36,733	$	772	$ 36,733	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PROPHETS RIVERVIEW **#** 0012955 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (4,617)	$	1
2	Cash-Patient Deposits	5,152		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	423,494		3
4	Supply Inventory (priced at COST)	23,529		4
5	Short-Term Investments	832,517		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,615		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,282,690	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	2,288,523		14
15	Leasehold Improvements, at Historical Cost	76,803		15
16	Equipment, at Historical Cost	798,812		16
17	Accumulated Depreciation (book methods)	(2,091,044)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	55,439		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Asset Mngmnt Purch	6,453		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,149,986	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,432,676	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 32,203	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	161,151		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	125,076		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Dpt - Apt	800		36
37	Group Ins-Emp Portion/Garnishmnts	(154)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 319,076	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 319,076	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,113,600	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,432,676	$	48

***(See instructions.)**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,160,752	1
2	Restatements (describe):		2
3	Net Income Unit 40 - Apartments	5,782	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,166,534	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,179	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Dnr Rst Prop/Oper Gft-Cash/End-Gen	(265)	15
16	Other (describe) Cash Asset Assess-CO/Intra-co n/a-CO	(56,848)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (52,934)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,113,600	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,749,603	1
2	Discounts and Allowances for all Levels	(295,647)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,453,956	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	4,299	5
6	Therapy	142,088	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 146,387	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	591	12
13	Barber and Beauty Care	2,994	13
14	Non-Patient Meals	11,293	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	101,202	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,597	19
20	Radiology and X-Ray	2,011	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 133,688	23
	D. Non-Operating Revenue		
24	Contributions	21,644	24
25	Interest and Other Investment Income***	(52,699)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (31,055)	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nsg & Medical Supplies	41,556	28
28a	Schedule Attchd	19,130	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 60,686	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,763,662	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	602,864	31
32	Health Care	1,260,455	32
33	General Administration	695,293	33
	B. Capital Expense		
34	Ownership	156,569	34
	C. Ancillary Expense		
35	Special Cost Centers	44,302	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,759,483	40
41	**Income before Income Taxes (line 30 minus line 40)****	4,179	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 4,179	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,872	2,067	$ 41,672	$ 20.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,112	9,590	169,233	17.65	3
4	Licensed Practical Nurses	7,866	13,887	210,666	15.17	4
5	Nurse Aides & Orderlies	51,085	59,500	550,337	9.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	390	453	7,319	16.16	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,549	1,824	20,121	11.03	9
10	Activity Assistants	4,913	5,570	44,316	7.96	10
11	Social Service Workers	1,837	2,024	28,183	13.92	11
12	Dietician					12
13	Food Service Supervisor	1,791	2,071	24,316	11.74	13
14	Head Cook	6,150	6,680	67,823	10.15	14
15	Cook Helpers/Assistants	10,010	11,414	92,214	8.08	15
16	Dishwashers					16
17	Maintenance Workers	4,299	4,807	48,446	10.08	17
18	Housekeepers	6,234	6,989	58,884	8.43	18
19	Laundry	6,509	7,017	53,849	7.67	19
20	Administrator	1,921	2,155	52,645	24.43	20
21	Assistant Administrator					21
22	Other Administrative	4,903	5,117	64,989	12.70	22
23	Office Manager	1,919	2,140	25,025	11.69	23
24	Clerical	1,927	2,139	19,438	9.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,843	2,083	21,861	10.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,130	147,527	$ 1,601,337 *	$ 10.85	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	124	$ 4,402	Ln 10, col 3	35
36	Medical Director	24	3,250	Ln 10, col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	112	2,025	Ln 10, col 3	39
40	Physical Therapy Consultant	444	20,829	Ln 10, col 3	40
41	Occupational Therapy Consultant	303	13,988	Ln 10, col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	25	1,916	Ln 10, col 3	43
44	Activity Consultant	43	1,820	Ln 10, col 3	44
45	Social Service Consultant	44	1,920	Ln 10, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,118	$ 50,149		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeannette Soleta	Administrator		$ 51,488
Vacation Accural			1,157
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 52,645

B. Administrative - Other

Description	Amount
Admin/Acctg	$ 110,555
TOTAL (agree to Schedule V, line 17, col. 3)	$ 110,555
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
BDO Seidman	Mdcre Cost Report Prep	$ 700
Berens & Tate	Employee Litigation	18,018
Good Samaritan	Medicaid Cost Report Prep	500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 19,218

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,937
Unemployment Compensation Insurance	6,855
FICA Taxes	117,915
Employee Health Insurance	152,388
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Taxable Gifts	625
Salary Reimb - Nrsng	(103)
Staff Pension	25,237
employee Physicals	171
Admin/Consultant Savings	1,929
TOTAL (agree to Schedule V, line 22, col.8)	$ 345,954

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,523
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues Reimbursement	3,018
Publications Reimb	4,567
Less: Publications Reimbursable	(3,440)
Less: Emloyeee Recruitment	(3,018)
Less: Public Relations Expense	( )
Non-allowable advertising	(2,523)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,127

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 282
In-State Travel	1,370
Seminar Expense	70
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,722

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1													$
2													
3													
4													
5													
6													
7													
8													
9	Painting - 6 restrooms	10/00	1,913	5				383	383	381	287		
10	Painting - Ceilings	2/01	51	5				10	10	10	10		
11	Painting	5/01	9	5				2	2	2	2		
12	Painting	6/01	8	5				2	2	2	1		
13	Painting	8/01	44	5				9	9	9	10		
14	Painting	8/01	31	5				6	6	6	8		
15	Painting	8/01	34	5				6	6	6	11		
16	Painting	9/01	48	5				9	9	9	16		
17	Painting	9/01	10	5				2	2	2	2		
18	Painting	9/01	17	5				4	4	4	3		
19	Painting	9/01	17	5				4	4	4	3		
20	TOTALS		$ 2,182		$	$	$	$ 437	$ 437	$ 435	$ 353	$	$

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA $3018**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,791** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **38,325**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **8,080**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? _____
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **58%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **HENRY SCHOLTEN & CO** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.